



STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS

DMHC / IMR 110 – 11/27/00

(To Be Completed By Treating Physician)

I hereby certify that I am the treating physician for _____ (enrollee's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the Health Plan's determination that the proposed therapy is Experimental and/or Investigational. I understand that in order for the Enrollee to obtain the right to an Independent Medical Review of this denial, as treating physician I must certify that the Enrollee's medical condition meets certain requirements.

In my medical opinion as the Enrollee's treating physician, I hereby certify to the following:

(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the member to qualify for an Independent Medical Review).

- ☐ 1) The Enrollee has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition.
- 2) The Enrollee has a condition that qualifies under one or more of the following:
[please indicate which description(s) apply]:
- ☐ Standard therapies have not been effective in improving the Enrollee's condition;
- ☐ Standard therapies would not be medically appropriate for the Enrollee; or
- ☐ There is no more beneficial standard therapy covered by the Health Plan than the therapy proposed.
- ☐ 3) The treatment I have recommended and which has been denied in my medical opinion, based on current clinical literature and medical evidence, is likely to be more beneficial to the Enrollee than any available standard therapies.
- ☐ 4) I certify this review must be completed within seven days for an expedited review and can not wait for a standard review. (See reverse side)

Contracted Providers: 1) Please state the evidence relied upon in this determination. Please provide a description below or attach to this request form, and fax to the Department.

2) Please provide a description of the experimental or investigational drug, device, procedure, or other therapy recommended for the patient. (Attach additional sheets as necessary.)

Non-Contracted Providers or Enrollees requesting Independent Medical Review on their own:

You are required to present or reference two documents to the Department of Managed Health Care from specialized medical and scientific literature sources to support the above certification that the requested therapy is likely to be more beneficial than any available standard therapy. Please refer to the reverse side that lists the medical and scientific literature sources, which qualify as supporting documentation for Independent Medical Review requests, the explanation for an expedited review, and fax or send via overnight mail.

Documentation may be forwarded by facsimile or overnight mail with this form to:
Department of Managed Health Care, HMO Help Center, IMR Unit, 980 Ninth Street, Suite 500, Sacramento, CA 95814.
If you have any questions, the Department can be reached at (888) HMO-2219, fax (916) 229-4328,
TDD (877) 688-9891, or the Department's web site at www.hmohelp.ca.gov.

Physician's Signature

Contact Telephone Number

Date

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**MEDICAL and SCIENTIFIC EVIDENCE WHICH QUALIFIES
FOR INDEPENDENT MEDICAL REVIEW REQUESTS
as DEFINED UNDER HEALTH and SAFETY CODE 1370.4(d)**

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not a part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
5. Findings, studies and research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Explanation for Expedited IMR Application Request

An expedited review is processed in seven days. A standard review is processed in up to 30 days. You must demonstrate that the treatment would be significantly less effective if not promptly initiated. Please provide your telephone number and/or pager number where you can be contacted.

Please provide the explanation for an expedited IMR application request:

Treating Physician Name

Telephone Number

Pager Number